Health Reform Commission
Executive Committee Meeting
Tuesday, June 14, 2011
Department of Administration, Conference Room A

I. Call to Order:
    a. The meeting was called to order by Lt. Governor Elizabeth Roberts, who announced that this meeting will focus on important policy issues relating to design of a RI Health Insurance Exchange that need to be brought up for discussion
    b. The presenters today are Ms. Deb Faulkner, Office of the Health Insurance Commissioner, and Mr. Jon Kingsdale, of Wakely Consulting Group, are here to present some of the issues this body must be aware.
II. Presentation: Health Insurance Exchange Planning for Rhode Island
    a. Ms. Faulkner presented on Background and Context.
        i. What is an exchange: The Health Insurance Exchange can be defined as a robust marketplace for all Rhode Islanders to identify health insurance options and purchase coverage, to help RI choose health insurance options, and to enroll in coverage
        ii. There are key deadlines to getting to 2014 in the Exchange build: By Jun 2011- legislation; By Sept 2011-Apply for Implementation Funds; By Jan 2013-Prove Readiness to the Feds; By July 2013-enroll RI in coverage.
            1. Legislation is needed in order to have the legislative authority, governance to apply for the implementation funds. A question was raised about legislative authority, if RI fails to pass legislation and doesn't create its own system then what occurs? It was determined that if RI fails to pass legislation creating its own Exchange then the state will default to the Federal Insurance Exchange plan.
        iii. Steps to 2014: Between March and September of 2011 the goal is to create a business plan. Then from June 2011 to March 2012 the work will begin on an Operational Design, and putting out RFPs. Then from January to December of 2012 the focus will be on "Build, Buy, Integrate."
        iv. RI Starting Point: Ms. Faulkner moved onto slides that discuss what are the strengths and limitations of a health care system in a state like RI.
            1. Size and Scale: In 2014 the ACA includes a Medicaid expansion, including everyone under 133% of the Federal Poverty Line (hereafter FPL). The Lt. Governor noted that in Massachusetts it appears they misestimated some of the projected data for who would

be covered and that created some problems. How was our data collected, can RI avoid a similar scenario? Ms. Faulkner stated that the data came from the ACS consultants to Medicaid, yet noted that the ACS data is not a RI specific survey of population needs. The data discussed presumes maximum enrollment of all those eligible in 2014 through the exchange. What constitutes "affordable" coverage for mandated individual purchasers of insurance is defined a graduated percentage of income.

a. A series of questions was asked by the Executive Committee members to clarify some points:

   If a large employer has employees that access a subsidy in order to participate in insurance coverage, there is a penalty on the large employer so as to limit that occurrence.

   There is a small percentage that will have the option to switch to the Exchange (some to Medicaid, but most to the exchange). Medicaid will cover childless adults up to 133% of FPL in 2014, and the program will ideally run as it does currently, likely through managed care.

   There was a request to look at states with similar population size to RI to determine how they are anticipating changes; what is the penetration into small businesses, what is the value add? There are many questions to be answered regarding the best way that an exchange can serve small businesses. The barriers in offering insurance to employees… penetration into small business? What is the value add, how does this improve what they have now?

2. RIte Care Program: Expanded RIte Care coverage already covers 9, 000 parents, 21,000 children above 133% FPL. Effective RIte Care procurement model provides a base on which to build, coupled with existing specialized Medicaid Managed Care Centers – a question that this raises is how will these existing plans chose to play in the exchange.
3. Individual Insurance Market: This market of individuals purchaseing their own health insurance will expand in 2014 as people are mandated to have

coverage. This will create changes in the risk management profile of the market. The state needs to be prepared to serve a much larger market. There will be some alignment between the Medicaid program and the exchange: management, procurement models.

a. Director Licht noted that this state has a significant number of mandated benefits, and inquired if in the event only 30 of the 42 state mandated benefits are in the essential benefit plan, does the federal government pre-empt the state rules? Ms. Faulkner clarified that if the state level benefit mandates exceed the federally designated essential benefits, the state can have continue to require these additional mandates for coverage but the Federal dollars will not support those items and thus state funds will need to be used to support the costs of that coverage for subsidized purchasers of insurance.
b. The state would have to assume the cost not only of the subsidies, but also the cost to unsubsidized individuals in the event that these mandates taek the costs for particular individuals above the percentage of income that is considered "affordable" in terms of the extra premium costs for these state only mandates, because then the state is the entity making the "not affordable" for certain individuals. Affordability is defined in the statute on a graduated scale of income. Right now the subsidy is fully funded by the states. It is a critical question to keep in mind in terms of lining up our RI commercial insurance statutes to the federal requirements once the federally determined essential benefit requirements are known.
c. There was a request from Secretary Costantino for a presentation on scenarios of payment and affordability: what the premiums are, what the delta is, what are different scenarios for this discussion of who pays the premiums, how much the subsidy will be etc. This request was noted by the staff for future discussion. This will require some of the economic modeling that is being conducted now by the consultants to the Exchange Interagency Planning Team.

4. Small Employer Coverage: Ms. Faulkner stated that the Exchange will have to create value for small employers

and that will be very difficult, and is not a problem that has yet been solved in other states. There is a goal to learn from the MA model, and the Utah model – both of which are different, but which have valuable lessons. Ms. Faulkner stated that in order to understand how to create value, there needs to be detailed conversations with employers and small businesses. Lt. Governor Roberts noted that this issue will need to come back to this group for further exploration after it is further developed through the RI Healthcare Reform Commission stakeholder process, which includes small business interests.

b. Jon Kingsdale, Wakely Consulting Group presented on models of the exchange to be explored. Mr. Kingsdale noted that one of the issues for a group like the Executive Committee is determining what the group needs to know, and what truly needs to be retained in order to make the correct policy level decisions and build an effective exchange here in RI. In other words, getting the right level of detail provided to a policy group like the Executive Committee.
    i. Key Strategic Questions: How to create a self sustaining RI Exchange; how best to serve low income RIers [those who are between 133-200%FPL]; How do we create value for individuals?; How do we create value for small employers? While keeping these questions in mind, the group is invited to consider models to create value for individuals, and that create value for small employers.
    ii. Three potential options for the Model for Individuals:
        1. (Option 1) Medicaid covers up to 133% FPL, above the 133% FPL would be covered by a "robust" Exchange which has full functionality for the consumer to purchase insurance through the exchange (as opposed to a website with information that then directs the consumer to another point, like an insurer, for the actual purchase).
        2. (Option 2)Medicaid covers up to 133% FPL, then those in 133-200%FPL are covered by the Basic Health Plan (an extension of Medicaid), and those above 200%FPL are covered by a "robust Exchange" with full functionality. It was noted that Option 2 is the exchange model that is conventionally outlined in the ACA. There were some committee members who questioned the value add presented by this option and it was agreed that each option has both strengths and challenges.
        3. (Option 3) Medicaid covers up to 133% FPL, the basic health plan covers those between 133-200% FPL, and those above 200%FPL utilize a "minimalist" exchange,

which is a website only (doesn't allow for transactions, merely provides information).

a. Commissioner Koller inquired if under the minimalist plan could some of the exchange functions, product definitions, rate negotiation, be done through a regulatory function? Mr. Kingsdale noted that in fact under ACA, the Federal government has delegated this decision to the states and it would appear that there is a grant of authority to regulate costs in this context.
b. It was also noted that the federal government has pegged the affordability subsidy to the "silver" level plan (referring to the amount of out of pocket costs the consumer would face in this level of plan). Thus the federal subsidies are linked to the costs of this level of plan.

iii. Potential Exchange Models for Small Businesses – Creating value for Small Employers.

1. **"Conventional" ACA vision**: Employer chooses a tier (Platinum to Bronze - Plan A through Plan C) thus creating one or more offerings on a plan matrix that the employees of that employer have available to them to sign up for through the exchange.
    a. Mr. Kingsdale noted that there are several intersecting variables – the proportion of the costs of insurance that the consumer will bear (the so-called precious metals, platinum, gold, silver etc.) as well as the "design of the plan" – is it a high deductible, low co-pay plan or a low deductible, high co-pay plan, or a low deductible, low co-pay. In addition to the overall portion of costs of coverage that falls on the consumer (the precious metals); the manner in which those costs are divided up (through deductibles and co-pays); there is also potential differntiation both in what services are covered (what is covered beyond the "essential benefits") and what the network of providers is.

    This results in at least four "sorting variables" that small businesses or individual purchasers would need to deal with to select coverage:

1. Precious metals (overall out of pocket costs to consumer – does the consumer pay 20% of overall cost, 30% etc.)
2. Method of paying your "share" – deductible and co-pay combinations
3. Covered services (does it go beyond the "essential benefits")
4. Provider network - are "your" doctors and preferred providers covered by the plan?

Given the complexity of these variables, the Lt. Governor noted that the driving value proposition of the exchange for most audiences will be making it easy for consumers and offering low cost options.

2. **Competitive award to one insurer** – select insurer with highest medical loss ration/lowest premium, outsource enrollment, billing, collections, customer service to the winning insurer. Make this offering to small businesses to respond to need to simplify, lower cost.
3. **Outsource to other state or regional exchange:** Outsource all functionality to an existing state exchange; consider developing an interstate compact to ease purchase by employers with employees in more than one state, as well as for employees who work in one state and live in another.
4. **Direct purchase by employees:** Possible "defined contribution" model, employer designates an amount that employees can use to buy on the exchange, employees choose the variables like precious metals and plan design. This could rely on infrastructure built to support a "robust" individual exchange [noted that Utah model is closest to this option].

iv. Combined Individual & Small Employer Models:
There are a large number of permutations that might combine options for the individual and small business approaches in a coordinated exchange that serves both groups. Although there are more options to discuss, Mr. Kingsdale initially presented five "combo plans" – combinations of approaches to individual exchange models and small business exchange models that are not incompatible on their face. These are five sample models that the group will dig into to determine whether they can be

built to be ACA compliant, sustainable and to add value to individual and business purchasers of insurance. Other possible combinations will also be explored but these five are logical jumping off points:

1. Basic Health Plan and Minimalist Individual Exchange + Competitive Award to One Insurer for Small Employers
2. Basic Health Plan and Minimalist Individual Exchange + Outsource Small Employer Exchange
3. Basic Health Plan and Robust Individual Exchange + Direct Purchase by Employees for Small Employers [Note: This model tries to induce the offering of the lowest priced plans]
4. Robust Individual Exchange + Direct Purchase by Employees for Small Employers
5. Robust Individual Exchange + Conventional Affordable Care Act Exchange for Small Employers [Note: This is a base case]

c. Director Licht pointed out that before the group can evaluate these models, the Executive Committee should present some basic goals and determine what values should be sought in the models. What are we, as policy makers, measuring the merits of these various combined models against? What goals is the state trying to meet in establishing the exchange and which of these models will best fulfill those goals?
d. The Lt. Governor stated that at the next meeting there will be work to lay out some guiding principles for what to assess, and once those are agreed upon there can be a further discussion in the Work Groups.

III. Adjourn: The meeting adjourned at 3:40pm.